Quality Improvement Plan – 2018/19 Workplan

AIM			CHANGE							
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Performance**	**Target for 2018/19**	**Target Justification**	**Planned Improvement Initiative (change ideas)**	**Methods**	**Process Measures**	**Target for Process Measures**	**Comments**
Effective	**Improve organizational financial health**	**Total Margin**: Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expenses, excluding the impact of facility amortization, in a given year. (Data source: Internal)	**Q2 2017/18** **0.99%**	**0%**	The organization has to have a total margin of greater than 0% to be financially viable and have a positive working capital position.	**1**.Providence Care will continue to review our cost and revenue structures and monitor our monthly financial results to ensure that we achieve the 18/19 target	**1.**Monthly Financial Performance reports and Financial Monitoring Reports provided to the Board Committee that is responsible for the financial condition review	**1.a** Monthly Financial Performance reports **1. b** Review of financial information at Operations Committee and Senior Leadership Team on a monthly basis.	**1.a** 100% review of monthly financial performance report by managers/directors **1. b** 100% review of financial information at Operations Committee and Senior Leadership Team on a monthly basis..	Providence Care has a robust and interprofessional HSFR Steering Committee to ensure that our systems are developed to support our financial and statistical data quality

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Effective	**Reduce potentially inappropriate use of antipsychotics in Long Term Care.**	**Reduce the percentage of residents receiving antipsychotics without a diagnosis of psychosis** (Data Source CIHI, CCRS).	**Q2 2017/18** **22.6%**	**21.6%**	An improvement of 1% per year x3 years will bring PM in line with or slightly better than, Provincial performance. 2018 represents year 1/3.	Focused audits to identify residents that have a history or current episode of psychosis that is not accurately reflected in their chart.	Collaborate with physicians to ensure that flagged charts are accurate	30 chart audits per month	100%	Data will also be gathered this year to reflect the number of residents who do not have the diagnosis of psychosis, but through our assessment and monitoring we know that their quality of life is improved with the use of antipsychotic medications and as such we consider their use to be appropriate.

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Person-centered	**Acknowledge complaints within 5 business days.** **PCH**	**Percentage of complaints acknowledged to the individual who made a complaint within three to five business days** (# of complaints acknowledged within 5 business days / Total number of complaints received in the fiscal year). (Data Source: internal)	**Collecting Baseline**	**100%**	In order to be compliant with ECFAA regulation that requires Hospitals acknowledge the complaints to the individual making the complaint **within 5 business days** of receiving the complaint.	1. Members of the Department of Quality & Risk Management will configure the electronic feedback system (wE-Care) to enable accurate capture of data related to acknowledge-ment of complaints. An alert will be sent to MRP's on day 5 if complaint has not yet been acknowledged.	1.Fields in the feedback form in wE-Care will be added/improved to include: -date complaint acknowledged/ date complaint received. - who acknowledged the complaint -method that complaint was acknowledged Alert to MRP's set up.	1.Revision of fields in wE-Care completed in order to capture data accurately effective April 1, 2018	1. Revisions to wE-Care **100%** complete.	

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Person-centered	**Maintain satisfaction scores in Palliative Care**	**Overall Satisfaction for Palliative Care:** **"What is your Overall satisfaction with care provided by the team?" (Responded satisfied or very satisfied). Internal family survey.** (Data source: internal survey)	**Year to Date** **Q2 2017/18** **95.3%**	**≥90%**	Maintaining satisfaction levels at or above 90% as a three year stretch target will allow for monitoring of trends over time and assessments based on yearly results verses quarterly. This is realistic given the fluctuation in the number of surveys returned each quarter. Our trend over time report for 2016/17 shows that satisfaction levels ranged from 84.3% to 98% with the number of surveys received ranging from 18 to27 with a total in 2016/17 of 93	**1-** Improve the Palliative Care Satisfaction Survey ensuring the information collected is a valuable tool for driving improvement. **2-** Improve awareness and understanding of satisfaction survey questions and results	**1**- Interdisciplinary team will review survey questions eliminating/revising those that are not relevant and including a question related to OT/PT services **2 a.** Provide education for H2 staff regarding the revised survey **2 b.** Satisfaction survey to be a standing agenda item at H2 staff meetings & process meetings immediately	**1**-% of questions reviewed and revised as necessary by April 1 2018 **2 a.** % of staff who have received education **2 b.** % of meetings with survey results discussion minuted	100% **2 a.**100% **2 b.** 100%	The goal in the first year of the three year plan is to make the satisfaction survey meaningful for both families and staff. The Palliative Care Team will develop a survey that provides a valuable opportunity for our families to communicate the experiences they had while at Providence Care, as well as providing valuable feedback for teams as they plan improvement initiatives.

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					completed surveys. The team will continue to evaluate quarterly and real time satisfaction of Palliative Care Patients' and families as a measure of improvement and to guide change ideas.		following quarter survey reports **2c.**Review results with Senior leaders and The Quality Improvement Team	**2 c**. % of quarterly meetings with survey results minuted	**2 c.**100%	
Person-centered	**Improve resident experience in Long-Term Care**	**Food in Long-Term Care:** Domains of Food (Data Source: NRC)	**Collecting Baseline**	**67%** of residents satisfied with their meal	67% will bring us back up to our 2016 performance	**1)**Culture Change Workshops for dietary staff	**1)**Collaboration between education and dietary manager to design and implement workshops	**1a)**Staff Participate in workshops **1b)** Staff will express understanding of content by explaining three main principles presented	**1a)** 50% of staff participate in workshop by February 2019 **1b)** 100% of staff in attendance	Our dietary team decided that smaller, more frequent surveys are a more accurate representation of the residents' dining experience. The NRC includes a question about the temp of the food, this is tightly controlled t cannot be changed. It also asks if they can get food they like, which is very difficult considering the backgrounds and cultural diversity of 243 residents. Asking the residents more frequently if

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						2) Implement "Sunday Dinners" weekly on each floor. **3)** Increase resident engagement and opportunities for feedback	**2)** Provide tablecloths, garnishes, "candles" **3)** Provide the residents with an opportunity to engage with the cooks that prepare their meal by having the cook and/or managers attend the RHAs during mealtimes and asking the residents if they enjoyed their meal.	**2)** Each RHA will have Sunday Dinners weekly **3)**Each RHA will be attended at least weekly	**2)** Sunday Dinners implemented by July 1st, 2018 **3)** 100% By July 1st	they enjoyed their meal is a better representation of the resident's mealtime experience in real-time rather than reflecting back on a year of meals.

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Safety	**Minimize the use of physical restraints in Seniors Mental Health-inpatient.**	**Physical Restraints in Seniors Mental Health:** Number of Seniors Mental Health quarterly assessments coded with physical restraint use in the 3 days prior to the assessment in the quarter divided by the total number of Seniors Mental Health quarterly assessments in the in the quarter. (Data Source: CIHI/OMHRS) **NOTE* This indicator captures the use of chair to prevent rising, mechanical, & physical/manual restraint. This indicator does not include chemical restraint, acute control medication or seclusion.**	**2017/18 Q2 50.9%**	**40%**	In 2017/18 the focus for this indicator was physical restraint use in Mental Health (all inpatient programs) occurring at quarterly assessment Change initiatives were created following a 2-year plan. Year 1 was focused on critically reviewing and analyzing CIHI and enhanced SafetE-Net data to gain a better understanding of current practice of physical restraint use. It has been identified that the Seniors Mental Health Program	1. Continue to critically review available CIHI and SafetE-Net physical restraint data each month at the Hospital Restraint Minimization committee and bi-weekly at the Seniors Mental Health Protective Device working group meeting to better understand current practice of use and to identify opportunities for improvement, and further education needs based on best practice and legislation.	1. Review and analyze restraint data provided by Decision Support and Quality and Risk.	1. The percentage of data received that is reviewed and analyzed by the committee.	1. 100% of the data provided will be reviewed and analyzed by the Hospital Restraint Minimization Committee and the Seniors Mental Health Team working group meetings to better understand current practice, look for root cause and identify opportunities for improvement with a focus on minimizing restraint use.	

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					has the highest quarterly occurrence of physical restraint and they are coded as being used primarily for the purpose of fall prevention. This year, the indicator and measure has been revised to reflect quarterly physical restraint use in Seniors Mental Health only. Our strategy over the next 3 years will focus on continuing to review and critically analyze physical restraint use in Seniors Mental Health while implementing and measuring identified change	2. Continue bi-weekly SMH team meetings to review and analyze client specific restraint use with a focus on identifying and implementing strategies and alternatives to restraint use including opportunities to trial discontinued use. 3. Continue to communicate restraint data with teams to enhance the understanding of current practice and ensure a consistent understanding	2. Review individual client specific use of restraints at bi-weekly meetings. 3. Reviewing of restraint data as a standing item at all Quality Team, Hospital Restraint Minimization Committee and Mental Health team meetings	2. The percentage of bi-weekly meetings where individual client specific use is reviewed and analyzed. 3. The percentage of Quality Team, Hospital Restraint Minimization Committee and Team meeting agendas that have	2. 100% of the meetings will be to review and analyze client restraint use. 3.100% of Quality Team, Hospital Restraint Minimization Committee, and Team meeting agendas will have reviewing	

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					ideas geared towards further minimizing use as well as minimizing the number of devices applied in keeping with our least restraint philosophy. For year 1of our 3 year plan, the target has been set at 40% which represents a decrease of 11% from our most recent performance. Our 3 year goal will be to reduce the use of physical restraints in SMH and be closer or better than the peer average.	of restraint definitions.	to ensure staff engagement, contribution to and sustainability of change ideas.	reviewing restraint data as a standing item.	restraint data as a standing item.	

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Safety	**Reduce hospital acquired infection rates in Providence Care Hospital.**	***Clostridium Difficile* Infection:** Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, and multiplied by 1,000 -consistent with publicly reportable patient safety data. (Data source: Internal)	**Year To Date as of Q2 2017/18** **0.08**	**0.22/1000** patient days	Our target is set based the Provincial Average for hospitals at 0.22/1000 patient days, as per HQO.	**1. a)** Minimize CDI spores in the health care environment for clients with CDI by cleaning /disinfecting client rooms / equipment with sporicidal product. **b.)**Perform regular Environmental Services (ES) and Infection Prevention and Control (IPAC) audits to review the effectiveness of environmental cleaning. **c)** IPAC will continue to utilize internal room picture to communicate with ES	**1a)** Environmental audits using audit tool developed and maintained by ES and IPAC. **b)** Review stats on a quarterly basis at IPAC Committee meetings. **c)** Room picture excel spreadsheet distributed weekly to Environmental	**1.)** Number of hand hygiene audits per fiscal year.	**1.)** ≥ 85%	Environmental cleaning is important to limit the number of spores in an environment that might be exposed to feces. Spores enter a patient through ingestion; proper hand hygiene by patients/ clients/ staff and visitors can help limit the ingestion of spores. Spores are resistant to killing by normal disinfectants, thus CDI cleaning in the environment requires use of a sporicidal product. b) Audits to include bathtub cleaning and equipment cleaning, adherence to wearing PPE for Contact Precautions for client care and ES cleaning. c) Room Picture distribution achieves regular communication of CDI cases between IPCPs and ES staff. The spread of the organism

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						regarding rooms requiring CDI cleaning. **2.)** IPAC will continue to monitor, and surveille CDI rates, report them quarterly to IPAC Committee meetings. **3.)** Annual education on applicable IPAC practices such as hand hygiene, CDI testing, use of personal protective equipment, and environmental cleaning.	Services (ES) by IPCPs. **2.)** Have CDI indicator on the agenda of quarterly IPAC and Antibiotic Stewardship Program (ASP). **3.)** Education Sessions: corporate education sessions, possibly on learning management system (LMS), and current staff education sessions.	**2.)** Percentage of IPAC, and ASP meetings with indicator / item on the agenda quarterly. **3.)** Percentage of current and new hire staff who receive IPAC education	**2.)** 100% **3)** 100% of new employees trained on CDI, routine practices and additional precautions, use of PPE, and cleaning of equipment	or the hardy spore is of primary concern, with more emphasis on antibiotic stewardship, and proper hand hygiene.

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Safety	**Improve hand hygiene rates in Providence Care Hospital**	**Hand hygiene compliance before patient/patient environment contact:** The number of times that hand hygiene was performed before initial patient/patient environment contact divided by the number of observed hand hygiene indications for before initial patient/patient environment contact multiplied by 100 - consistent with publicly reportable patient safety data. (Data source: Internal)	**Year To Date as of Q2 2017/18** **89%**	87.5%	The 2018/19 target remains the previous target for 2017/18 as we recognize our Hand Hygiene compliance rates have decreased. Our rates have decreased because we had student auditors, staff were and still are becoming familiar with their new surroundings, we had competing operational readiness demands, and we were auditing using only one device. We only started auditing using 3 devices since September 2017. Another reason as to why	**1.** Maintain or increase number of audits performed. **2.** Monthly and quarterly reporting of hand hygiene rates and audits. **3.** Post monthly hand hygiene rates on each	**1.** Utilize the Handy Metric Audit tool. Audits will be performed by Infection Control, and Prevention Practitioners (IPCPs), volunteers, and students. **2**. Performance (compliance) will be posted on each unit. As well as quarterly results will be sent to each unit via email and reported to IPAC committee. **3.** Posters on the shared visual	**1.**) Number of hand hygiene audits per fiscal year. **2.)** Percentage of IPAC, and ASP meetings with indicator / item on the agenda quarterly. **3.)** Percentage of audited	**1.)** 400 audits **2.)**100% **3.)** 100%	Continuance of regular monitoring by IPCPs of audits performed on a weekly, monthly and quarterly basis will help to ensure our target is being met. Compliance Reports to IPAC committee and managers and staff will provide awareness of hand hygiene compliance rates for specific units and programs as well as highlight locations where improvements can be made. Structural changes such as the new staff hand hygiene sinks will make hand washing more accessible for all. Patients/Clients on contact precautions will be taught when and how to sanitize and wash hands. Hand sanitizer to be available at or near patient/client bedside where it is safe to do so. Hand hygiene information has been included in the

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					we would like to keep the same target is we had planned to increase our number of auditors by having units perform audits; however, this request has not been supported at this time.	unit. **4.a)**Reinforce that Hand Hygiene performance is an organizational priority for client and staff safety **4.b)** Increase awareness of hand hygiene program for staff, patients/clients and families.	communication monitors on all audited units. 4)**a/b** Increase amount of hand hygiene dispensers to provide accessibility. **4.a/b)**Signage is on alcohol-based hand rub machines, visual communication monitors, information in-patient, client/ resident /family handbooks IPAC staff talking to stakeholders will increase awareness of	units with hand hygiene rates posted each month. 4. Percentage of audited units with posters displayed that inform people of our hand hygiene (HH) program	**4.)** 100%	patient/client handbooks. This information will assist in educating patient/clients and their families about the importance of hand hygiene and proper technique. Rates posted on audited units will also increase awareness and engagement for staff and patient/client/family in hand hygiene rates. Hand hygiene rates will also continue to guide the direction of IPAC education.

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						5. Ongoing Education, i.e. annual session, Just in Time feedback, and on an as-needed basis. Develop a Hand Hygiene education module on LMS.	the Hand Hygiene Program. **5)** Education Sessions. Patients/Clients and families will receive education on the importance of hand hygiene via patient/client and family handbooks and by IPCPs as requested	**5)** Percentage of current and new hire staff who receive Infection Prevention and Control (IPAC) education annually.	**5.)** 100%	

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Safety	**Reduce incidents of Workplace Violence**	**Number of reported workplace violence incidents by hospital workers** **PCH** (where "workplace violence" and "worker" are as per the definitions in the OHSA) (Data source: Internal)	**Colleting Baseline**	**Colleting Baseline**	As of April 2017 we are an organization with a blending of rehabilitation, complex care & mental health services being provided at our new hospital site. Additionally, in April/17 we moved to a new version of our SafetE-Net incident reporting system. In the coming year we will focus on changes and communication that encourage reporting.	**1)** Conduct a review of the organization's Workplace Violence Prevention Program and develop an action plan to address gaps/areas for improvement. **2)** Make changes/customizations to the reporting system (SafetE-Net) to capture more detailed information, specific to incidents of	**1)** OHS to lead the review in consultation with others including members of the JHSC and the Violence subcommittee of the JHSC using the PSHSA's Workplace Violence Assessment Checklist **2) a.** Assess data/information needs and compare to current state. **2) b.** Engage Quality & Risk to discuss options for	**1) a.** Review is completed. **1) b**. % of Action Items on track for completion as per agreed upon timeline. **2) a.** Assessment complete. Yes/No **2) b.** Changes and customizations	**1) a**. 100% of the review is completed by end of Q1. **1) b.** 80% of action items are on track for resolution as per agreed upon timeline. **2) a.** Assessment 100% complete no later than end of Q1. **2) b**. 80% of	**2) a**. Develop a communication & training plan to ensure all employees and service providers aware of and understand the changes & rationale, and why reporting incidents of violence is important. **2) b.** Will need to build

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						violence.	improving and develop a plan for making the improvements.	made in the system.	required changes are on track as per the established timeframes determined by Quality & Risk Mgmt. and OHS.	reports within the system based on new data reporting capabilities.
						3)a. Conduct our annual WPV risk assessments for all areas/units with more focused/in depth reviews in clinical areas at highest risk of violence.	**3) a.** Determine which units require a modified/more in-depth risk assessment based on the incidence and severity of violent episodes.	**3) a.** Completion rate for Violence Risk assessments.	**3)a.** 100% completion of risk assessments for each identified area.	
						3) b. Develop action plans to address the identified areas of opportunity.	**3) b.** Review available risk assessment tools to develop a	**3) b**. % of items on the action plan that are on track for	**3) b**. 80% of items on the action plan are on track for resolution	

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							more customized assessment tool specific to the setting. **3) c** Provide all other units/dept. with the existing/standard risk assessment template for completion. Develop action plans to address systemic and/or unit/dept. specific issues that are identified through the risk assessments.	completion as per agreed upon timelines	as per agreed upon timeline. .	

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						4) Explore auditing capabilities related to the new violence flagging system in the electronic patient records system.	**4)** Pull together a team to examine system reporting capabilities and develop an auditing plan.	**4)** % of flagged patients with a care plan in place that includes measures to be taken to prevent/ manage aggressive/ violent behaviour.	**4)** 80% of the established quarterly target is achieve	**4)** Note- targets for quarterly compliance will progressively increase